**BIOCARE INFUSION**
ONCOLOGY & THERAPEUTICS

# ACTEMRA (TOCILIZUMAB) INFUSION ORDERS

**FAX:** 470.922.3656 | **PHONE:** 470.377.6400

## PATIENT INFORMATION:

Fax completed form, insurance information, and clinical documentation to 470.922.3656

Patient Name: _____ DOB: _____ Phone: _____

**Patient Status:** ☐ New to Therapy ☐ Continuing Therapy **Next Treatment Date:**

## MEDICAL INFORMATION

**Diagnosis:** ☐ Rheumatoid Arthritis ☐ Polyarticular Juvenile Idiopathic Arthritis
☐ Systemic Juvenile Idiopathic Arthritis ☐ Acute Graft Versus Host Disease
☐ Giant Cell Arteritis ☐ CRS ☐ Other: _____

**ICD-10 Code:** _____

PatientWeight:_____lbs.(required) Allergies:_____

## THERAPY ORDER

**Actemra Orders:**

☐ 4mg/kg IV every 4 weeks for _____ doses, followed by 8 mg/kg IV every 4 weeks thereafter x 1 year
☐ 4mg/kg IV every 4 weeks x 1 year ***DOSE NOT TO EXCEED 800MG IN RA/CRS DIAGNOSIS***
☐ 8mg/kg IV every 4 weeks x 1 year ***DOSE NOT TO EXCEED 600MG IN GCA DIAGNOSIS***
☐ Other dose: _____ mg IV every 4 weeks x 1 year
☐ Other: _____

**Lab Protocol:**

**All dx:** Obtain CBC w/diff, LFTs, and Lipid Panel prior to 1st infusion
**RA/GCA:** CBC w/diff, LFTs, and Lipid Panel prior to 3rd infusion
All subsequent infusions - CBC w/diff q 3 mos; LFTs q 4-8 weeks for 1st 6 mos, then q 3 mos
**PJIA:** CBC w/diff, LFTs, and Lipid Panel prior to 2nd dose; then CBC w/diff & LFTs q 4-8 weeks
**SJIA:** CBC w/diff & LFTs prior to 2nd dose; Lipid Panel between 4-8 weeks; then CBC w/diff & LFTs q 2-4 weeks

**Additional Lab Orders:** _____ **Frequency:** _____
☐ TB ☐ QFT Screening yearly (optional) ☐ Baseline HepBcAB total
Required labs to be drawn by: ☐ Biocare Infusion ☐ Referring Provider

Other orders: _____

## PROVIDER INFORMATION

By signing this form and utilizing our services, you are authorizing *Biocare Infusion,* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Provider Name: _____ Signature: _____ Date: _____
Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____
☐ Opt out of Biocare Infusion selecting site of care (if checked, please list site of care):

## SERVICE AREAS

City: _____ State: _____ *View our locations here:*

BIOCARE INFUSION
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# COMPREHENSIVE SUPPORT FOR ACTEMRA (TOCILIZUMAB) THERAPY

## PATIENT INFORMATION:

Patient Name: _____ DOB: _____

## REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

☐ Include signed and completed order (MD/prescriber to complete page 1)

☐ Include patient demographic information and insurance information

☐ Include patient's medication list

☐ Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy

☐ Rheum - Has the patient had a documented contraindication/intolerance or failed trial of a DMARD, NSAID, or conventional therapy (i.e., MTX, leflunomide)? ☐ Yes ☐ No
If yes, which drug(s)? _____

☐ Rheum - Does the patient have a contraindication/intolerance or failed trial to at least one biologic (i.e., Humira, Simponi, Xeljanz, infliximab)? ☐ Yes ☐ No
If yes, which drug(s)? _____

☐ CRS dx - Has the patient received treatment with a chimeric antigen receptor T cell therapy (i.e., Kymriah, Yescarta) or Blincyto? ☐ Yes ☐ No If yes, which drug(s)? _____

☐ Include labs and/or test results to support diagnosis

☐ Rheumatoid Factor or anti-CCP (attach results)

☐ Temporal artery biopsy or cross-sectional imaging or acute-phase reactant elevation (GCA dx)

☐ *If applicable* - Last known biological therapy: _____ and last date received: _____.
If patient is switching to biologic therapies, please perform a wash-out period of _____ weeks prior to starting Actemra.

☐ Other medical necessity: _____

## REQUIRED PRE-SCREENING

☐ **TB screening test completed within 12 months - attach results**
☐ **Positive** ☐ **Negative**

☐ **Hepatitis B screening test completed (Hepatitis B surface antigen) - attach results**
☐ **Positive** ☐ **Negative**

☐ **CBC w/diff, LFTs, Lipid Panel - attach results**

*If TB or Hepatitis B results are positive - please provide documentation of treatment or medical clearance, and a negative CXR (TB+)

Biocare Infusion will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

**Please fax all information to (470) 922-3656 or call (470) 377-6400 for assistance**